

Recovery Works Helpful Hints

INSURANCE

In a case where a participant's insurance company denies payment for a service rendered, a provider may submit the denial from the insurance company to Recovery Works to review for payment through Recovery Works. All insurance denials should be sent utilizing the JIRA system only. Please include a copy of the exact insurance denial form from the insurance company as an attachment to your ticket. Providers have 60 days from receipt of the denial to send to Recovery Works.

SUBJECT: INSURANCE DENIAL

DESCRIPTION: What service did insurance deny? Why did the insurance company deny the service? What service are you requesting to bill? How many units are being requested to bill? Does insurance pay for other substance abuse/mental health services?

ATTACHMENT: An exact copy of the insurance denial with the reason for denial highlighted

Acceptable Insurance Denials for consideration:

1. The individual has reached the allotted maximum for the service category
2. The service is not part of the participant's plan (if alternate comparable service is available, participant must utilize that service).
3. The individual was not covered during the time of service (individual was awaiting insurance coverage during that time period).

Please note, Recovery Works does not cover Out of Network Denials. The participant must visit a provider within his/her network. Recovery Works will also not pay for a provider who is not credentialed to provide the service with the insurance company.

PRIOR AUTHORIZATIONS

All prior authorizations should be completed electronically, including the exact provider information, as well as the individual's DARMHA ID. Additionally, the individual must have a WITS ID assigned through DARMHA. Recovery Works does not accept hand written forms. This form should be sent to Recovery.Works@fssa.in.gov. Prior authorization requests must be individualized, and should not be "standard" for each individual. Should a PA request be submitted that does not have all information or is not individualized, the request will be denied and a new PA request will need to be submitted once the information has been added. Additionally, any approved PA can only be retroactive two business days from the date of submission.

CAP INCREASE REQUEST

CAP increase requests can be submitted if the provider feels the participant needs more funds than the cap allows. Requests are determined on a case by case basis, for extenuating circumstances (i.e., individual has maxed out insurance), and should not be utilized as a norm for providers. Recovery Works takes into account any previous expenditure the individual has utilized on services, the individual's insurance efforts and the treatment plan of the individual currently in treatment.

SUBJECT: CAP INCREASE REQUEST

DESCRIPTION: What service and dollar amount are being requested? What extenuating circumstance exists to warrant a cap increase? Has the individual previously requested a cap increase? How will the individual pay for subsequent services beyond the increase request? Does the individual have insurance?